



FACE Program Fact Sheet

Fatality Assessment and Control Evaluation

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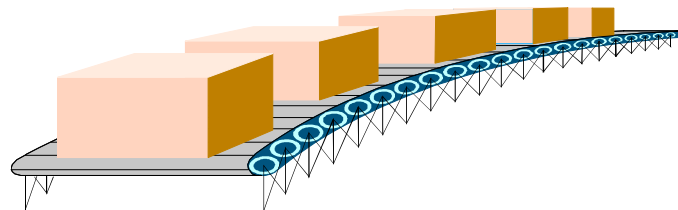
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WORKERS PINNED AND KILLED BY MOVING PARTS OF CONVEYOR EQUIPMENT IN TWO SEPARATE INCIDENTS

BACKGROUND

The Wisconsin Fatality Assessment and Control Evaluation (FACE) Program receives reports of fatal occupational injuries in Wisconsin. Two of those occurred when workers were caught and pinned between parts of moving conveyor equipment.

This fact sheet describes those incidents and requests that occupational safety professionals and employers who use conveyor equipment bring the following recommendations to the attention of conveyor operators and others who work around conveyors.



THE INCIDENTS

Incident #1

A 52-year-old male machinist died when he was pinned between a turnstile arm and a projecting metal beam on a conveyor system downender table. There were no guards in place at the pinch point between the beam and the turnstile arm. The worker paused the automatic cycle to manually push a metal coil from a turnstile to the downender, then returned the system to the automatic cycle. He returned to the turnstile area, and apparently forgot the machine was cycling. A supervisor heard the victim yell, then saw he was pinned. He went to the control panel and unsuccessfully tried to retract the beam. He then cut the hydraulic line to retract the beam and free the victim.

Incident #2

A 46-year-old male utilities worker died after being pinned by a belt conveyor at a paper company. The conveyor started and stopped automatically as fuel

was needed by the company's steam plant. The victim apparently entered the enclosed area where the conveyor pulley was located to tighten the conveyor belt. He either stepped or fell onto an unguarded section of the moving conveyor belt, and was pinned between a wall and the metal chute frame that extended over the belt. A co-worker found the victim after searching for him when he did not take his lunch. He used a radio phone to contact the control room and emergency medical services.

RECOMMENDATIONS

Employers who use conveyor systems should:

- **install guards on conveyor systems wherever workers may have contact with the moving parts.**
- **ensure that lockout/tagout programs cover all workers while they work near moving equipment.**

The Wisconsin Department of Health and Family Services, in agreement with the National Institute for Occupational Safety and Health (NIOSH) conducts research on occupational fatalities. The Fatality Assessment and Control Evaluation (FACE) Program focuses on identifying factors that increase the risk of work-related fatal injuries. The Wisconsin FACE Program helps in the development and use of improved safety measures for preventing fatal work injuries.

PLEASE POST

FACE information is produced and distributed to provide current, relevant education on methods to prevent severe work-related injuries.

If you have comments or questions, please call the FACE Project at 608/266-7298, or write:

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